Lutheran Health Network
Lutheran Hospital
Transplant Center

Living Donor Information

Name: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

What is the best phone number to reach you during business hours? _____

Email Address: _____

Race: _____ Marital Status: ☐ Single ☐ married ☐ divorced ☐ separated ☐ cohabitating

Are you a U.S. citizen: ☐ yes ☐ no Social Security Number: _____

Education level: ☐ grade school ☐ high school ☐ college/tech school ☐ post – graduate

What is your current employment status? ☐ Full Time ☐ Part Time ☐ Self-employed ☐ Unemployed

Do you currently have health insurance? ☐ yes ☐

Do you currently have a primary care physician (PCP)? ☐ Yes ☐ No

Primary Care Physician Name: _____ Phone number: _____

Additional physician name: _____ Specialty: _____

Additional physician address: _____ Phone number: _____

Additional physician name: _____ Specialty: _____

Additional physician address: _____ Phone number: _____

Kidney Transplant Recipients Name: _____

Relationship to Patient: ☐ Family: sibling, parent, etc ☐ other family: in-law ☐ Friend ☐ co-worker

☐ None I do not have a specific person in mind ☐ other: _____

How were you referred to consider donation at Lutheran Hospital: ☐ by a patient ☐ friend/family
☐ media source ☐ other _____

Name_____ Date of Birth _____

General Health Questions

Height: _____ Weight: _____

When were you last seen by your family doctor: _____

Are you being pressured or forced into donating your kidney? ☐ No ☐ Yes If YES, please explain:

_____

Are you being offered any compensation for donating your kidney? ☐ No ☐ Yes If YES, please explain:

_____

Is your spouse/significant other supportive of your decision to donate a kidney? ☐ No ☐ Yes

Is your employee willing to give you time off for the evaluation and recovery after donating? ☐ No ☐ Yes

MEDICAL HISTORY: (include year of diagnosis please)	**SURGICAL HISTORY:** (include year please)
Diabetes / Gestational Diabetes:	None:
Kidney disease (stones etc):	Heart Surgery:
Hypertension (High Blood Pressure):	Carotid Surgery:
Cancer:	Gall Bladder/Appendectomy:
Heart Disease:	Tonsillectomy:
Lupus:	Prostate Surgery:
Stroke:	Other urologic surgery:
Chronic infections (TB etc):	Amputation:
Lung Disease:	C-Section/Hysterectomy:
History of Blood Clots:	Breast Biopsy:
Seizures:	Other Biopsy:
Hepatitis/liver disease/jaundice:	Any complications from anesthesia
HIV/AIDS:	What is your blood type?
Other:	Colonoscopy:

MEDICATIONS: (please indicate dose and frequency)

_____

_____

Please list any **allergies** to medications and what reaction they cause:

_____

Are you married? ☐ No ☐ Yes Are you divorced? ☐ No ☐ Yes

Do you have children? ☐ No ☐ Yes If so, how many? _____ Ages: _____

Do any of your children have significant health problems? ☐ No ☐ Yes explain: _____

Who would be available to help you around the time of surgery? _____

Use of alcohol: ____ Never ____ occasionally ____regularly ____previously, but quit

How much & how often do you drink? _____

Use of tobacco: ____ Never _____ Packs per day _____ previously, but quit

Use of illegal drugs: _____ Never _____ Yes (what kind) _____ previously, but quit

FAMILY HISTORY (list which family members have the following?)

Liver Disease:		High Blood Pressure:
Kidney Disease:		Heart Disease:
Diabetes:		Cancer:
Bleeding Disorder:		Stroke:
	Age	**Health Problems/Cause of Death**
Mother ☐ Alive ☐ Deceased		
Father ☐ Alive ☐ Deceased		
Number of Sisters: Number of Brothers:		

REVIEW OF SYSTEMS

GENERAL		**MUSCULOSKLETAL**	
Fever	NO YES	Joint Pain/Swelling	NO YES
Fatigue	NO YES	Muscle/Joint Weakness	NO YES
Insomnia	NO YES	Back Pain	NO YES
Stress	NO YES	Cold Extremities	NO YES
Chills/Night Sweats	NO YES	Numbness/Tingling in Arms or Legs	NO YES
EYES, EARS, NOSE, MOUTH, THROAT		Varicose Veins	NO YES
Eye/Vision Problems	NO YES	**BREAST**	
Hearing Loss/Ringing	NO YES	Breast Pain or Lump	NO YES
Earaches	NO YES	Nipple Discharge/Bleeding	NO YES
Nosebleeds	NO YES	Any lumps in armpit	NO YES
Frequent Colds	NO YES	**NEUROLOGIC/PSYCHOLOGIC**	
Dental Problems	NO YES	Frequent Headaches	NO YES
Sore Throat/Hoarseness	NO YES	Lightheaded/Dizzy	NO YES
Swollen Glands	NO YES	Paralysis	NO YES
HEART AND LUNGS		Depression/ Psychiatric problems	NO YES
Chest Pain	NO YES	**ENDOCRINE**	
Irregular/Fast Heartbeat	NO YES	Osteoporosis/bone disease	NO YES
Shortness of Breath	NO YES	Excessive Thirst or Urination	NO YES
Swelling of Feet/Ankles	NO YES	Heat or Cold Intolerance	NO YES
Cough	NO YES	Thyroid Problems	NO YES
Asthma/Wheezing	NO YES	**SKIN**	
Coughing up phlegm	NO YES	Rash/Itching	NO YES
Spitting up Blood	NO YES	Bleeding/Bruising	NO YES
GASTROINTESTINAL	NO YES	Change in Skin/Hair/Nails?	NO YES
Abdominal Pain	NO YES	Any tattoos/body piercings?	NO YES
Nausea/Vomiting	NO YES	**PAST OR CURRENT INFECTIONS**	NO YES
Diarrhea	NO YES	Chicken pox	NO YES
Constipation	NO YES	Hepatitis A / B / C	NO YES
Change in Bowels	NO YES	HIV	NO YES
Hemorrhoids	NO YES	Herpes	NO YES
Bleeding	NO YES	Tuberculosis	NO YES
GENITOURINARY		Other Infections	NO YES
Frequent urination	NO YES	**MALES (ONLY)**	
Pain or Burning with Urination	NO YES	Pain or Swelling in Testicle	NO YES
Bladder Control Problems	NO YES	Prostate Problems	NO YES
Blood in Urine	NO YES	Erectile dysfunction	NO YES
Kidney Stones	NO YES	**FEMALES (ONLY)**	
Change in Force or Stream	NO YES	Severe Cramps or Irregular Menses	NO YES
Decreased Daily volume in Urine	NO YES	Heavy Bleeding with menses Date of last menstrual period _____	NO YES
Sexually Transmitted Disease:	NO YES	History of abnormal Pap Smear Date of last Pap Smear _____	NO YES
BLEEDING DISORDERS		History of abnormal Mammogram Date of last Mammogram _____	NO YES
Slow to Heal after Cuts	NO YES	How many Previous Pregnancies	
Anemia	NO YES	Diabetes in Pregnancy	NO YES
Blood Clots or Phlebitis	NO YES	High Blood Pressure in Pregnancy	NO YES
Any religious/ethical concerns regarding blood	NO YES	How many full-term deliveries	

transfusions?			
Any bleeding problems	NO YES	How many miscarriages/Abortions	

Name: _____ Date of Birth: _____

Completion of this routine health survey is required in order to be considered as a potential living donor.

I, _____, give my permission to be contacted by the Lutheran Hospital Kidney Transplant Center to receive more information about living donation.

☐ **Yes I do** ☐ **No; I do not give my permission to have my blood type and tissue typing lab work drawn as part of the initial screening to be a potential living kidney donor.**

I understand that by giving my permission to be contacted and/or have screening labs drawn requires no further commitment to proceed with evaluation for living donation.

Signature: _____ Date: _____

Lutheran Hospital Use Only

Referral initiation form received by: _____ Date _____Time _____

Reviewed by: _____ Date: _____ Time: _____

Discussed with potential donor: Date: _____ Time: _____ Initials: _____

Education session scheduled with donor: Date: _____ _ Time: _____

Lutheran Health Network
Lutheran Hospital

Dear Potential Living Donor,

Lutheran Hospital Kidney Transplant Center would like to thank you for your interest in becoming a living donor! The Lutheran Hospital transplant team is committed to helping you help others. The living donors have to undergo numerous testing to make sure that someone is suitable for the donation process.

To begin the referral process, please complete this survey and return to the Living donor coordinator via fax at 260-435-6279, e-mail at vbarto@lutheran-hosp.com, send back with your potential recipient or in the mail.

Our address is: Lutheran Hospital – Kidney Transplant Center

ATTN: Valerie

7910 W. Jefferson Blvd Suite 200

Fort Wayne, IN 46804

If you have any questions or concerns please call 260-435-6211. Thank you again.

Sincerely,

Valerie Barto RN, BSN, CCTC

Supervisor & Living donor Coordinator